SPECIALTY INFUSION CENTERS

KRYSTEXXA ORDER FORM
(Pegloticase)

FAX TO: 800-540-1852

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F

Ht: _____ WT: _____ lbs / kg Primary Language: _____ Allergies: _____

Patient Preferred Location: ☐ Staten Island ☐ West Harrison ☐ Manhattan ☐ New Paltz ☐ Bronx ☐ Syosset ☐ Port Jefferson ☐ Millburn ☐ Brooklyn Heights ☐ Paramus

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (provide complete specific code)

☐ M1A. _____ 0 Chronic Gout, w/o Tophi

☐ M1A. _____ 1 Chronic Gout, w/ Tophi

Other: _____

Prescribing Information

It is recommended that the patient discontinue oral urate-lowering medications 2-3 days (up to one week) before starting Krystexxa.

RECENT DATA SUGGESTS THAT PATIENTS MAY HAVE IMPROVED OUTCOMES WHEN IMMUNOMODULATORS ARE TAKEN WITH KRYSTEXXA.

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
LAB RESULTS: G6PD, baseline uric acid > 6.0 mg/dL.

PRESCRIPTION

Pre-Medications

Required:
Acetaminophen: 650 mg PO, may repeat q 4-6 hours, PRN infusion reaction Diphenhydramine: 25 mg IVP, may repeat q 6 hours, PRN infusion reaction Methylprednisolone: 125 mg SIVP
Other: _____

Patient has tried and failed

☐ Feboxustat
☐ Allopurinol

Krystexxa (pegloticase)

Dose:
☐ IV: Infuse 8 mg every 2 weeks for one year

Post Treatment Observations: The patient is observed for 60 minutes following each infusion.

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Supervising Provider (if applicable) _____

Date: _____ NPI#: _____ Specialty: _____

Practice Name: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____